INITIAL PATIENT INTAKE FORM

NAME: _____

Date of Birth: _____ / _____ / _____ **Gender**: ☐ Male ☐ Female

Address: _____

City: _____ : **State**: _____ **Zip Code**: _____

Preferred method of contact. For internal use only.

Home Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Cell Phone: _____ ☐ Morning ☐ Afternoon ☐ Evening

Email: _____

Primary Care Physician: _____

MMJ Authorizing Physician: _____

Registered Caregiver (if applicable): _____ Phone Number: _____

A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please have them register for their card.

How did you hear about us?

- ☐ Website
- ☐ DHSS
- ☐ News Article
- ☐ Search Engine
- ☐ Leafly
- ☐ Referred
- ☐ Facebook
- ☐ Instagram

My State Approved Diagnosis: (Please check what applies below)

- ☐ Cancer
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Intractable migraines unresponsive to other treatment
- ☐ A chronic medical condition that causes severe, persistent pain or persistent muscle spasms, including but not limited to those associated with multiple sclerosis, seizures, Parkinson's disease, and Tourette's syndrome
- ☐ Debilitating psychiatric disorders, including, but not limited to, post-traumatic stress order, if diagnosed by a state licensed psychiatrist
- ☐ Human immunodeficiency virus or acquired immune deficiency syndrome
- ☐ A chronic medical condition that is normally treated with a prescription medications that could lead to physical or psychological dependence, when a physician determines that medical use of marijuana could be effective in treating that condition and would serve as a safer alternative to the prescription medication
- ☐ A terminal illness
- ☐ In the professional judgment of a physician, any other chronic, debilitating, or other medical condition, including, but not limited to, hepatitis C,
- ☐ Amyotrophic lateral sclerosis, inflammatory bowel disease, Crohn's disease, Huntington's disease, autism, neuropathies, sickle cell anemia, agitation of Alzheimer's disease, cachexia, and wasting syndrome.

INITIAL PATIENT INTAKE FORM

Negative symptoms that I am currently experiencing: (Please check what applies below)

☐ Abdominal Pain / Cramping
☐ Difficulty Falling Asleep
☐ Anxiety
☐ Depression
☐ Difficulty Remaining Asleep
☐ General Insomnia
☐ General Pain
☐ Ocular Pressure
☐ Tremors
☐ Hyperactive Bowels
☐ Muscle Pain
☐ Poor Appetite
☐ Migraine
☐ Nausea
☐ Seizures
☐ Other: _____

Frequency of Symptoms:

Additional Health Conditions:

Current Medication	Dosage

Allergies: _____

Alternate Medicine	Vitamins

INITIAL PATIENT INTAKE FORM

Do you smoke Tobacco? (Please check one): ☐ Yes ☐ No

Do you drink Alcohol? (Please check one): ☐ Yes ☐ No

I have used Cannabis (Marijuana) anytime in the past: ☐ Yes ☐ No

Please Describe Negative Effects Experienced using Cannabis (if applicable):

Positive Effects Experienced using Cannabis (ifapplicable):

Positive outcomes I hope to achieve using Medical Cannabis:

My Preferred Method of Cannabis Consumption: (Please check what applies below)

☐ Vaporized or Smoked ☐ Topical

☐ Capsules/Liquids ☐ Patches ☐ Edibles

☐ Sublingual (Tinctures) ☐ Suppositories ☐ I am uncertain

I am looking for Cannabis with: (Please check what applies below)

☐ High THC ☐ Low THC ☐ High CBD ☐ Low CBD

☐ 1:1 Ratio THC / CBD ☐ I am NOT sure of my medical needs

Frequency of use (if applicable):

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ **Date of Birth:** _____

I understand, that under the Health Insurance Portability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read, and understand the Notice of Privacy Practices. Organic Remedies reserves the right to change the terms of its Notice of Privacy Practices. I understand Organic Remedies will provide a current Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

Authorized Patient's Representative: _____

Relationship: _____

Signature: _____

---------- **FOR OFFICE USE ONLY** ----------

I was unable to obtain the patient / patient's representative's signature.

Employee's Name: _____ **Date:** _____

Reason: _____

Patient & Caregiver Purchase Disclosures

Please read all information below, initial beside appropriate lines and sign to acknowledge these disclosures and confirm understanding.

Organic Remedies encourages patients new to medical marijuana therapy to receive a pharmacist consult. However, if you have received a consult with a pharmacist at another location prior to visiting us or feel comfortable in your knowledge of appropriate therapies for your condition, you are not required to have a consultation with a pharmacist. Our pharmacists are available to schedule follow-up consults as needed to help you maximize therapy.

- I would like to schedule a pharmacist consult. _____
- I decline an initial pharmacist consult. _____

Patient/Caregiver understands that they are prohibited from consuming medical marijuana in **public spaces** and also will not do so within 1000 feet of the facility or in any other place prohibited by law. Medical marijuana should only be consumed in private locations not generally open to the public. _____

Under the law of the State of Missouri, I understand that I am not immune from the imposition of any civil, criminal, or other penalties for:

- Operating, navigating, or being in physical control of any motor vehicle, boat, or aircraft while under the influence of medical marijuana.
- Consumption of medical marijuana in any public place
- Consumption of medical marijuana in a motor vehicle
- Undertaking any task under the influence of medical marijuana when doing so would constitute negligence or professional malpractice. _____

It is unlawful for anyone other than the Patient/Caregiver to possess or use medical marijuana. I understand it is illegal to divert, transfer, sell, or give this or any medical marijuana products to anyone other than the Patient/Caregiver to whom it was dispensed. I agree to keep all medical marijuana away from children, other than the patient. _____

It is unlawful under Federal Law, to possess, use manufacture or distribute Marijuana. I understand obtaining medical marijuana under Missouri Regulations does not exempt me from Federal prosecution, under the laws and penalties provided by the Federal government. _____

I understand that scientific research has not established the safety of medical marijuana use by pregnant women and nursing mothers and should not be consumed during pregnancy or while breast feeding. _____

Patient & Caregiver Purchase Disclosures

It is the principle mission of the FDA Center for Drug Evaluation and Research to ensure drugs marketed in the United States are safe and effective. The center ensures that drugs work correctly and that their health benefits outweigh their known risks. Medical marijuana remains a Schedule 1 substance under the Controlled Substance Act, and as such has not received FDA approval. I understand the use of medical marijuana to treat a medical condition is not yet approved by the U.S Food and Drug administration. _____

Organic Remedies is committed to supporting our patients in reaching their individual treatment goals. Our pharmacists are available for telephonic or video consults during facility open hours. We encourage all Patients/Caregivers to check in regularly and disclose any concerns related to their therapy. I understand and acknowledge that open communication with my pharmacist is available to me to maximize my therapy. _____

Missouri regulations allow qualifying patients to purchase, or have purchased on their behalf by their primary caregivers, no more than four (4) ounces of dried, unprocessed marijuana per qualifying patient, or its equivalent, in a thirty- (30-) day period.

I confirm I have read, understand, acknowledge, and affirm the above statements. My initials beside each line and signature below document my understanding and acknowledgement of this information.

_____ _____

(Signature) (Date)

_____

(Print Name)